STATE OF ALABAMA
DEPARTMENT OF FINANCE
DIVISION OF RISK MANAGEMENT
STATE EMPLOYEE INJURY COMPENSATION TRUST FUND (SEICTF)

EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

___ Report to be completed by supervisor or other designated authority.
___ All questions must be answered.
___ Type or print

SEND TO: State Employee Injury Compensation Trust Fund
Division of Risk Management
P. O. Box 303250
Montgomery, AL 36130-3250
24 hr. **FAX: (334) 223-6170 or 1-888-827-6753**

This report must be completed and FAXED to the Division of Risk Management within 24 hours of the injury. If you are unable to FAX, the injury may be reported by calling: 1-800-388-3406, 8 AM to 5 PM, Monday thru Friday. After hours injury reports should be FAXED or called in at the beginning of the next working day.

1. Name of Injured Employee (Please type or print)
(Last) (First) (MI)

2. SSN _____ - ___ - _____

3. Date of Birth ___/___/_____

4. Sex _____ M _____ F

5. Home Address
(No. and Street)
(City or Town)
(State)
(Zip)

6. Phone Home ( ) _____
Work ( ) _____
Cell ( ) _____
Work Hours: From: _____ To: _____

7. Job Title

8. Status _____ **Full Time**
_____ **Part Time**
_____ **Contract**

9. Job Code

10. Employing Agency **Agency Number**

11. Division, District, etc.

12. Agency Address (No. and Street) (City or Town) (State) (Zip)

13. Date of Injury _____/_____/_____

14. Date Employer Notified ___/___/_____

15. Time of Injury _____:_____ _____AM _____ PM

16. Is employee covered by State Employee Medical Insurance? _____ **Yes** _____ **No**

17. At this time, has the injury or illness required medical treatment? _____ **Yes** _____ **No** **(If YES, complete 18 & 19.)**

18. Name and address of treating physician:

19. Name and address of hospital:

_____ Hospitalized _____ Outpatient _____ Emergency Treatment _____ NONE

20. City or town where injury occurred:

21. Was injury caused by a motor vehicle accident? _____ **Yes** _____ **No**

22. Was more than one person injured in this incident? _____ **Yes** _____ **No**

23. Describe fully what happened to cause the injury or illness and indicate the body part(s) affected:

24. Were there any witnesses to the injury? _____ **Yes** _____ **No** **(If yes, give name, address and phone number.)**

25. Signature of supervisor reporting incident **Print Name** **Phone** (Daytime) **Date**